Evaluation of the Accountable Care Collaborative
Executive Summary

This report describes the results of our two-year study, funded by The Colorado Health Foundation and Rose Community Foundation, of the impact of Colorado's Accountable Care Collaborative on health care utilization, costs, and quality. The quantitative analysis examined administrative claims data between July 2009 and June 2015, a period that spans the introduction and establishment of the Accountable Care Collaborative. The qualitative portion of our mixed methods evaluation of the Accountable Care Collaborative is focused on experiences and perspectives of provider practices with the program to date. We have also incorporated findings focused on member experience from a companion study conducted by TriWest Group.

The Accountable Care Collaborative reduced spending while maintaining quality

Overall, we find that the Accountable Care Collaborative was successful at reducing health care related expenditures and that the reduction in expenditures was persistent over time. The estimates reveal that the Accountable Care Collaborative saved about $60 per member per month (PMPM) in health care spending on adults and $20 PMPM in health care spending on children. The savings grew over time, making us confident that these savings will persist. The savings among Medicare and Medicaid eligible (MME) members were estimated to be about $120 PMPM. We find that contemporaneously funded grants and Center for Medicare and Medicaid Innovation (CMMI) initiatives also contributed to declines in spending. Controlling for these initiatives lowers the estimated savings estimate by about 20%. The Accountable Care Collaborative did not significantly influence official key performance indicators or other recognized indicators of quality and access. Taken together, we interpret these findings as an indication that the Accountable Care Collaborative program increased the value of Health First Colorado services by reducing spending while keeping quality of care constant.

Practices in the Accountable Care Collaborative viewed the program positively

Practices generally shared positive perspectives of the Accountable Care Collaborative. The biggest driver of practice perceptions was the push for enhanced care coordination. Many also stated that the Accountable Care Collaborative has been a step toward much needed health care reform in Colorado. Some practices shared that the Accountable Care Collaborative initiated a much larger discussion and coordinated effort toward health care reform among various entities that previously were not communicating or coordinating efforts as effectively. Practices also shared that the Accountable Care Collaborative program was consistent with ongoing efforts to enhance care coordination with many practices crediting specific efforts to enhance care coordination tied to elements of the Accountable Care Collaborative.

Practices expressed divided opinions on Key Performance Indicators (KPIs)

Practices expressed a variety of opinions about the Key Performance Indicators **(**KPIs) associated with the Accountable Care Collaborative. Some clinics stated that they felt the KPIs were generally good measures of a practice's performance. However, even these clinics noted that some of the KPIs were more relevant than others. The majority of clinics stated that they felt at least some of the KPIs were not appropriate or were not good indicators of a practice's performance. Interestingly, different clinics referenced different KPIs as good indicators versus poor indicators. The quantitative analysis of the KPIs revealed that performance on the measures improved equally for Accountable Care Collaborative members and fee-for-service (FFS) clients reflecting contemporaneous trends.

Statewide Data Analytics Contractor (SDAC) brought value but improvements are needed

The majority of clinics recognized the potential of the use of high-quality, timely data in care coordination and decision-making but struggled to make the data available in SDAC actionable. Many clinics noted that members they do not see are attributed to their clinic and that members that are seen by their clinic are not attributed to them. Several pediatric clinics also noted that adult members were inappropriately attributed to their clinic. Even among the clinics that valued the data from SDAC, workarounds were sometimes put in place to extract relevant data from SDAC for members of the clinic in order to make it actionable.

Regional Care Collaborative Organizations (RCCOs) provided new capacity for practice-specific initiatives and needs

Practices generally report positive experiences and interactions with their RCCO(s) but also great variability in how they interact and the specific activities they engage in with their RCCO(s). Practices tended to value interactions with their RCCO(s) when those interactions were based on practice specific and initiated needs. These interactions with RCCOs were frequently initiated by practices that wanted assistance in areas such as quality improvement initiatives, practice transformation efforts to enhance care coordination, and relationship building with community partners to enhance care coordination. The impact of the Accountable Care Collaborative on total spending on adults also varied considerably by RCCO: two of seven RCCOs experienced reductions of less than $40 PMPM. In contrast, only one RCCO experienced reductions of less than $20 PMPM on children. Two RCCOs experienced twice the average PMPM savings on MME members.

Member education remains an opportunity for improvement

Many practices noted that members need to play a more active role in the Accountable Care Collaborative program if it is to be successful. Practices recognized the key role that "patient satisfaction" plays in the Accountable Care Collaborative and contemplated using it as a future KPI. Several practices noted that members would benefit from more education, engagement, and accountability, as many lack a fundamental understanding of preventive care and how their Primary Care Medical Providers (PCMP) can help. Practices perceived the financial incentives for members to be misaligned with KPIs because members have no co-pay for emergency department (ED) visits but have a copay to see their PCMPs. However, virtually all practices acknowledge that this population has more unmet socioeconomic basic needs which need to be overcome before members become more involved in their own care.

Conclusions

Our findings suggest that the Accountable Care Collaborative program has decreased total spending on health care services on a PMPM basis while maintaining quality of care. This decrease in spending is likely due in part to practice and RCCO efforts to enhance care coordination through various practice transformation efforts initiatives Many of the practices participating in the Accountable Care Collaborative have only recently implemented care coordination improvements or are in the midst of ongoing quality improvement efforts to enhance care coordination, and RCCOs have helped to support these new initiatives.

Given the timeliness of these efforts by RCCOs and practices, it may be that the full effect of their efforts on utilization, cost, and quality measures has yet to be realized. RCCOs and practices should continue to be supported in their ongoing efforts to enhance the coordination and quality of the care of their members. These supports may include: continued funding to support care coordination; access to timely data; support on how to integrate care coordination efforts into the practice; performance indicators that align with practice specialty and care coordination approach; and member education, engagement and accountability.